MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14301 — 15927

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JACOB	Middle: M.	Last: ADKINS	2a. DATE OF DEATH Month: SEPT	Day: 24	Year: 1970	2b. HOUR: M
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: JULY 15, 1894	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: WORCESTER Md.				
10. CITY OR TOWN OF DEATH: BERLIN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): —	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FARMER	12b. KIND OF BUSINESS OR INDUSTRY: SELF EMP				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: WOR.	13c. CITY OR TOWN: BERLIN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: R F D,			
14. FATHER'S NAME First: JACOB	Middle: M.	Last: ADKINS	15. MOTHER'S MAIDEN NAME First: MARY EMMA	Middle:	Last: MORRIS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown: YES	(If yes give war or dates of service): WORLD WAR I	16b. SOCIAL SECURITY NO.	17. INFORMANT: MRS. JACOB M. ADKINS	Address: BERLIN RFD MD			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hepatic coma

DUE TO, OR AS A CONSEQUENCE OF

(b): Carcinoma of colon

DUE TO, OR AS A CONSEQUENCE OF

(c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1538

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

ASCVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 9 Nov., 19 69, to 24 Sept., 19 70, that (I) (we) last saw the deceased alive on 15 Aug., 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~saw~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Jack C Lewis	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 27 Sept 70
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 9/28/70	23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN	23d. LOCATION (City or Town): BERLIN	(County): WOR.	(State): MD
24. FUNERAL DIRECTOR: Anna A. Burbage	ADDRESS: Berlin Md.	25a. REC'D BY REGISTRAR DATE: OCT 13 1970	25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers		

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14302

CERTIFICATE OF DEATH

14323

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
   c. LENGTH OF STAY IN 1b: All Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 409 Covington St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
   d. STREET ADDRESS: 409 Covington St
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ellen — Middle: D — Last: Allen

4. **DATE OF DEATH**: Month: 9 — Day: 11 — Year: 1970

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 28 1873

9. AGE (In years last birthday): 97 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): Snow Hill

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Dennis

14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-30-7791

17. INFORMANT: Beatrice Allen — Address: 409 Covington St Snow Hill Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

DUE TO (b): ARTERIO SCLEROSIS — 4 YRS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HAD A "STROKE" SEVERAL YRS AGO — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from AUG 15 1970, to SEPT 11, 1970, that (I) (~~we~~) last saw the deceased alive on SEPT 11 1970, and that death occurred at 1 P M, from the causes and on the date stated above.

22a. SIGNATURE: Robert C. LaMar M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-11-70

22c. PHYSICIAN'S NAME (Type): Robert C. LaMar, M. D. — 22d. ADDRESS: 104 Bay Street, Snow Hill, Maryland 21863

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 9-14-70 — 23c. NAME OF CEMETERY OR CREMATORY: Ebenezer — 23d. LOCATION (City, town or county) (State): Snow Hill Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Jolley Funeral Home - Salisbury — ADDRESS

25a. REC'D BY REGISTRAR DATE: SEP 25 1970 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A1S (4)
20M S-63

1

FOR STATE HEALTH DEPT.

Items 21a--21f, 22a
Film 429 10/13/70 mh
14303

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14328

1. DECEASED-NAME (Type or Print): First: Tisha; Middle: Ann; Last: Fields Marshall

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month: Sept. Day: 22 Year: 1970

2b. HOUR: 2:30 PM

3. SEX: Female

4. RACE: Negro

5. DATE OF BIRTH: July 22, 1970

6. AGE (In years last birthday): IF UNDER 1 YEAR — MONTHS: 2 mos. DAYS: ; IF UNDER 24 HRS. — HOURS: MIN.:

2c. DATE PRONOUNCED DEAD: Month: September Day: 22 Year: 1970

2d. HOUR: 3:45 PM

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Worcester Md.

10. CITY OR TOWN OF DEATH: Pocomoke City

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress):

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.):

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Worcester

13c. CITY OR TOWN: Pocomoke

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET AND NUMBER: Rt. #2 Box 3

14. FATHER'S NAME: First: Albert Middle: Lost: FieldsIII

15. MOTHER'S MAIDEN NAME: First: Ruth Middle: Elizabeth Lost: Marshall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16b. SOCIAL SECURITY NO.:

17. INFORMANT: Mother ADDRESS: Rt. #2 Box 3 Pocomoke City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

911X

IMMEDIATE CAUSE (a): Asphyxia

DUE TO, OR AS A CONSEQUENCE OF

(b): Aspiration of food material --Milk

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gove rise to immediote couse (a), stoting the underlying couse lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year: HOUR A.M. 3:00 P.M. 9/22 1970

21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.): While nursing--(feeding) Baby evidently aspirated milk

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.): Home

21f. LOCATION Street or R.F.D. No.: Rt.2, Box 3 City or Town: Pocomoke City County: Wor., State: Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinian death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Jesus G. Santiano M.D.

EXAMINER'S NAME (Type): Jesus G. Santiano, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: 9-24-70

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9 26 70

23c. NAME OF CEMETERY OR CREMATORY: St.Paul Cem. Old

23d. LOCATION (City or Town) (County) (State): Stockton, Maryland

24. FUNERAL DIRECTOR: Samuel Lowe ADDRESS: New Church, Md.

25a. REC'D BY REGISTRAR DATE: SEP 29 1970

25b. REGISTRAR'S SIGNATURE: Charles Judge

WIC - 30F40

VR A15ME (5)
10M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

FOR STATE HEALTH DEPT.

Items 11,18,19 Film 430 11/2/70 mh

14304

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14324

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1. DECEASED-NAME (Type or Print) First: GARNET	Middle: JOHN	Last: GLASER	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month: 9 Day: 20 Year: 1970	2b. HOUR: 9 A M		
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: 9/1/13	6. AGE (In years last birthday): 57 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month / Day / Year 19	2d. HOUR: M	
7a. BIRTHPLACE (State or foreign country): PENN	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Worcester Md.			
10. CITY OR TOWN OF DEATH: OCEAN CITY	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): DOA MEDICAL CENTER	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENN.	13b. COUNTY: FRAN	13c. CITY OR TOWN: MERCERSBURG	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 1 NORTH MAIN ST.		
14. FATHER'S NAME First: CHARLES	Middle: B.	Last: GLASER	15. MOTHER'S MAIDEN NAME First: LAURA	Middle:	Last: GLASER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WWII	16b. SOCIAL SECURITY NO.: 199-07-8271	17. INFORMANT: EVA GLASER (WIFE)	ADDRESS: (SAME)			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): UNDETERMINED Sub-total occulsion of

DUE TO, OR AS A CONSEQUENCE OF: coronary arteries due to

(b): Arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: UNDETERMINED

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Found unconscious this morning

Abdominal distress 12 hours ago

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Harvey G. Klein M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☑

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: September 20, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/24/70	SPRING GROVE	LEMASTERS FRANKLIN PA

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Anna A. Rudasyl	Berlin Md	SEP 22 1970	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14305 — 14325

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Ethel	Middle:	Last: Godfrey	2a. DATE OF DEATH Month: 9 Day: 1 Year: 70	2b. HOUR: M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Oct. 29, 1896	6. AGE (In years last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Worcester Md.			
10. CITY OR TOWN OF DEATH: Bishopville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: Worcester	13c. CITY OR TOWN: Bishopville	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: -		
14. FATHER'S NAME First: George	Middle:	Last: Hudson	15. MOTHER'S MAIDEN NAME First: Laura	Middle:	Last: Hudson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: -	17. INFORMANT Address: Ruth Bunting, Bishopville, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): A S C V D. — unknown
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/24

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Rheumatoid arthritis

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from Sept 20, 19 66, to Sept 1, 19 70, that (I) ~~(we)~~ last saw the deceased alive an Aug 31 19 70, and that in ~~(my)~~ ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(we)~~ ~~(did)~~ ~~(did not)~~ view the body after death.

22b. SIGNATURE: Jack Lewis — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 9/10/70

22d. PHYSICIAN'S NAME (Type): Jack C. Lewis, M.D. — 22e. ADDRESS: Selbyville, Del.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9/5/70	23c. NAME OF CEMETERY OR CREMATORY: Bishopville Cem.	23d. LOCATION (City or Town) (County) (State): Bishopville, Wo., Md.	
24. FUNERAL DIRECTOR: C. Vaughn Melson	ADDRESS: Frankford, Del.	25a. REC'D BY REGISTRAR DATE: SEP 16 1970	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

VR A15 (4)
45M - 1/69

Item 18 Film 428 9/22/70

14306

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14326

FOR STATE HEALTH DEPT. 1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1. DECEASED-NAME (Type or Print)	First: Robert	Middle: M.	Last: Harrison	2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐	Month: 9	Day: 6	Year: 1970
2b. HOUR OF DEATH	5:18 P.M.						
3. SEX	M	4. RACE	W	5. DATE OF BIRTH	May 2, 1919	6. AGE (In years last birthday)	51 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.						
2c. DATE PRONOUNCED DEAD	Month: 9	Day: 6	Year: 1970	2d. HOUR	5:18 P.M.		
7a. BIRTHPLACE (State or foreign country)	Md	7b. CITIZEN OF WHAT COUNTRY?	US	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑	9. COUNTY OF DEATH	Worcester	Md.
10. CITY OR TOWN OF DEATH	Ocean City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Medical Ctr. 1001 Philadelphia Ave	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md	13b. COUNTY	—	13c. CITY OR TOWN	Balto	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 115 Rock Glen Rd
14. FATHER'S NAME First / Middle / Last		15. MOTHER'S MAIDEN NAME First / Middle / Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	Yes	(If yes, give war or dates of service)	WW2	16b. SOCIAL SECURITY NO.	217 09 1198	17. INFORMANT	family ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema, Coronary Throm. — Pending post-mortem
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCVD with Severe Coronary Sclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 Min. / Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Angina

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Richard H. Glew M.D.
EXAMINER'S NAME (Type): Richard H. Glew
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑ Acting
22b. DATE SIGNED: 9/16/70
ADDRESS (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
burial	9/10/1970	Balto. National	Balto. County, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. F. EVANS & SON	8802 Harford Rd.	SEP 10 1970	J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14307

14327

1. DECEASED-NAME (Type or print): First: Mary; Middle: S.; Last: Johnson
2a. DATE OF DEATH: Month: Sept.; Day: 23; Year: 1970
2b. HOUR: 11:45 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: March 5, 1894
6. AGE (In years last birthday): 76 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: Worcester Md.
10. CITY OR TOWN OF DEATH: Snow Hill
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 108 N. Church St.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Snow Hill
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 108 N. Church St.
14. FATHER'S NAME First: Goldsborough; Middle: ; Last: Shockley
15. MOTHER'S MAIDEN NAME First: Eleanora; Middle: ; Last: Mumford
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 217 36 0542
17. INFORMANT: Thomas J. Johnson Jr. Address: Snow Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CACHEXIA + ANEMIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WKS
DUE TO, OR AS A CONSEQUENCE OF
(b) CARCINOMA OF COLON — 6 MOS
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1538

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
POOR RENAL FUNCTION

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from JAN 1, 1970, to SEPT. 23 1970, that (I) (we) last saw the deceased alive on SEPT 20 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert LaMar — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 9-25-70
22d. PHYSICIAN'S NAME (Type): Robert C. LaMar, M. D.
22e. ADDRESS: 104 Bay Street, Snow Hill, Maryland 21863

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Sept. 26 1970
23c. NAME OF CEMETERY OR CREMATORY: Bates Meth.
23d. LOCATION (City or Town) (County) (State): Snow Hill Md.
24. FUNERAL DIRECTOR: Norman T. Lemmon ADDRESS: Snow Hill Md.
25a. REC'D BY REGISTRAR DATE: SEP 28 1970
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14308

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15934

1. DECEASED-NAME (Type or Print) First: Francis	Middle: G.	Last: Leake	2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ Month: Sept. Day: 29 Year: 1970	2b. HOUR: 4:30 M			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Aug. 16 1903	6. AGE (In years last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month / Day / Year 19	2d. HOUR: M		
7a. BIRTHPLACE (State or foreign country): Illinois	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	B. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Worcester Md.				
10. CITY OR TOWN OF DEATH: Snow Hill	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 210 S. Washington St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Store Keeper	12b. KIND OF BUSINESS OR INDUSTRY: Grocery				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Snow Hill	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 210 S. Washington St.			
14. FATHER'S NAME First: Richard	Middle	Last: Leake	15. MOTHER'S MAIDEN NAME First: Emily	Middle	Last: Loar		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214 32 7081	17. INFORMANT: Mrs. Willie E. Leake	ADDRESS: Snow Hill, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Harvey S. Klein M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 10/6/70

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY ~~OR CREMATORY~~	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 1, 1970	Snow Hill Christian	Snow Hill Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Truman F. Lemmon	Snow Hill, Md.	OCT 9 1970	J. Charles Judge

VR A15ME (5)
10M REV. 1/68